15-0900-16509-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Lyngblomsten Health Center, Survey Completed 02/17/05

RECOMMENDED DECISION

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Beverly Jones Heydinger on June 10, 2005 at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, MN 55401. The meeting concluded on that date.

Appearances: Marci Martinson, Facility and Provider Compliance Division, Department of Health, 1645 Energy Drive, Suite 300, St. Paul, MN 55108-2970. Amy Wiffler, Administrator, Lyngblomsten Care Center, 1415 Almond Avenue, St. Paul, MN 55108. Also attending were Mary Cahill, Gloria Derfus and Elizabeth Swan for the Department of Health, and Brenda Johnson, John Maidl and Martha McCusker, M.D., for Lyngblomsten Care Center.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made, and for the reasons set out in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

That citation F-316 for Resident 17 is supported, but the severity level of G is not supported and should be adjusted to level D.

Dated this 16th day of June, 2005.

/s/ Beverly Jones Heydinger
BEVERLY JONES HEYDINGER
Administrative Law Judge

MEMORANDUM

Citation F-316 – Quality of Care – Incontinence Care

Resident 17 was a 94-year-old woman who was diagnosed with dementia, recurrent urinary tract infection (UTI), delusions, hallucinations, and small vessel CVD.[1] She had been a resident at Lyngblomsten for approximately four years.

The surveyor, Elizabeth Swan, observed the personal cares given to Resident 17, and found a violation of § 483.25 (d)(2), Quality of Care. The guidance for surveyors states: "A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible."

Resident 17's quarterly minimum data set was completed on November 23, 2004 and showed that the resident had severely impaired cognition, and required extensive assistance for transfers and toilet use. She was frequently incontinent of bowel and bladder.[2] The care plan also reflected that the Resident was incontinent. There was no disagreement that the Resident's overall condition was such that she was not expected to resume normal bladder function. Thus the focus was on the adequacy and implementation of the care plan for prevention of incontinent-related complications and maintaining resident dignity.[3]

Resident 17's care plan reflected that she was incontinent daily, and her relevant goals were to keep the resident dry and odor free, to prevent UTI, and to keep her skin intact. Interventions were listed on the care plan, including, "Toilet at least upon arising, after meals, HS, and PRN [and] at 4 a.m.; Provide pericare when incontinent as needed; Be alert to potential for UTI; [follow up] on changes in urine color, odor; and Meds per MD orders."[4]

The record shows that the resident had a bad case of Clostridium Difficile (C-Diff) with massive diarrhea some months prior to the survey. As a result, her skin was discolored and sensitive.[5] It is not clear that the resulting skin discoloration was reflected in the care plan. A chart note on February 13, 2005 at 9:10 p.m. stated that the resident had a large loose stool and redness and rash in the perineal area. "Butt paste" was applied as directed.[6]

As part of her plan of care, Resident 17 had an "Ineffective Coping" Plan. It shows that the resident got angry with others, had a history of resisting personal cares, and refused to allow staff to change or reposition her. She asked repetitive questions, was easily annoyed, and frequently complained about her health.[7] The facility regularly monitored the resident's pain, noting that she frequently yelled, but denied actual pain.[8]

On February 14, 2005, the surveyor observed Resident 17 from 4:25 p.m. to 8:00 p.m. (3 hours, 35 minutes), and the resident was not toileted during that time. She was given dinner at approximately 5:30 p.m. At around 7:15 p.m., the resident asked for help and complained of pain. She was given medications and a nutritional supplement.[9] At 7:30 p.m., staff began to prepare the resident for bed. She resisted and slapped at the nursing assistant. At 8:00 p.m., the resident was transferred to bed,

and her incontinence brief was changed. It was soaked with urine, and contained a small amount of loose stool. The perineal area was very red. The resident cried out when the nursing assistant attempted to do perineal care, and pushed the assistant's hand away.[10]

On Form 2567, the surveyor stated that the nursing assistant said that the redness was "new" since he had last cared for the resident, but that is not reflected in the surveyor's contemporaneous notes.[11] The nursing assistant was aware of the resident's prescribed butt paste and did apply it. The same nursing assistant indicated that the resident had been in a wheelchair when he began his shift at 3:00 p.m., and had not been toileted until 8:00 p.m. when the resident was prepared for bed. The facility disputes this, and states that other caregivers were available to toilet the resident. However, the surveyor did not observe any caregiver toilet the resident between 4:25 and 8:00, including the time after the evening meal. The facility also disputes that the incontinence brief could have been soaked with urine because the resident consumed very little liquid. However, the surveyor was quite certain, and there was no evidence that the staff member who changed the brief disagreed with the characterization.

On February 15, 2005, the surveyor observed the resident from 6:10 a.m. to 9:40 a.m. (3 hours and 30 minutes). The resident was in bed and was not toileted during the observation. The resident cried out when the nursing assistant performed the perineal care. The surveyor stated that the nursing assistant did not apply a protective cream to the resident's buttocks. The facility disputes this. It claims that the "butt paste" was a prescription medication that was ordered only when stool was present in the incontinent pad. In other instances the facility staff routinely used "Tena" skin-caring wash cream to clean the area, and it included protective cream. This was a normal part of the cleaning, but was not separately charted because Tena is not a prescription drug. The facility compared its use to toothpaste – a routine part of the personal cares, but not separately documented.

The order for the butt paste, and its listing on the treatment record, show that it is to be applied twice a day, a.m. and at hour of sleep (HS), and after each stool.[12] Based on the order, the butt paste should have been applied with the morning personal cares.

At the conclusion of the survey, the surveyor spoke to John Maidl, a nurse with responsibility for Resident 17's care, about her care and the surveyor's concern about the redness. Mr. Maidl promptly checked the resident, but did not observe that her condition had changed from the normal amount of redness that she experienced. Similarly, following the surveyors' meeting with the facility administration, three nurses immediately checked Resident 17 to determine whether her condition had changed, and concluded that it had not.

During her conversation with Mr. Maidl, the surveyor got the impression that the resident was toileted at 4:00 a.m., on February 15, and not again until she got up. The facility disputes this, and refers to the care plan. However, the facility offered no

evidence that the resident was toileted between 6:10 a.m. and 9:40 a.m., the period of the surveyor's observation.

The facility denied that staff had treated Resident 17 in a manner that had harmed her. The staff showed that it had taken steps to reduce the frequency of UTI's, and because of the resident's light weight, bony protuberances, and poor nutrition, that only careful attention could have prevented any breaks in the resident's skin. It is apparent from the record that, overall, the staff were attentive to the resident and had prevented skin deterioration, despite the resident's lack of mobility, physical condition and incontinence. Nonetheless, it is also clear that her skin care and toileting during the survey did not match her care plan.

This deficiency was classified at level G, an isolated deficiency with actual harm that is not immediate jeopardy. Because the facility failed to show that Resident 17 was toileted with the frequency set out in the care plan, or that the butt paste was applied as ordered, the deficiency is supported. There was no evidence that the resident was toileted after she had her dinner on February 14, and no evidence that she was toileted at a morning hour that one would ordinarily associate with getting up. The resident didn't feel well and stayed in bed until after 9:30 a.m. on February 15, but that does not explain why the facility failed to toilet her earlier in the morning, at a time more logically associated with getting up, given that she was incontinent and at risk of skin problems. The Department also showed that the butt paste was not applied during personal care on February 15, as ordered.

Although the Department supported the deficiency, it failed to show why a level G was appropriate. There was no evidence of actual harm to this resident. The Facility demonstrated that redness in the perineal area was the "baseline" for this Resident, that its adherence to her care plan had decreased the frequency of UTI, and some of the discoloration was an expected outcome from her prior Clostridium Difficile, with resulting diarrhea. Four staff members who were familiar with the resident checked her after the surveyor questioned the perineal redness, and did not note any change or deterioration in the resident's condition. Although the resident cried out, that was also routine for the resident. The surveyor's notes show that the cries of pain began before the resident was touched, and the resident's records reflect that she resisted personal cares and touching. The facility staff regularly assessed the resident's pain, and routinely differentiated between actual pain and her aversion to being assisted. Although it is possible that the resident was experiencing unusual pain when the surveyor observed her, it is more likely that she was engaging in her typical behavior. Although there was the <u>potential</u> for harm, commensurate with Level D, the Department failed to show that there was any <u>actual</u> harm to the resident. Thus, Level D more accurately reflects the violation.

B.J.H.

[1] Ex. 3.
[2] Ex. B-38.
[3] Ex. A-13.
[4] Ex. 2.
[5] Ex. B-14.
[6] Ex. B-10.
[7] Ex. 4.
[8] Ex. 5.
[9] Ex. B-6.
[10] Ex. B-6.
[11] Compare Ex. A-16 and B-6.
[12] Exs. 10 and 11.